JAY D. FULLMAN A PROFESSIONAL CORPORATION
800 South Beach Boulevard, Suite A
La Habra, California 90631
Telephone (562) 694-6005 or (714) 255-2960 Facsimile (562) 697-7700

ADVANCE HEALTH CARE DIRECTIVE QUESTIONNAIRE

1. Your Full Name: _____
   Address (Home): _____
   _____
   Phone (Home): _____

2. Whom do you desire to act as Agent to make health care decisions on your behalf if you become unable to do so?

   a. Agent's Full Name: _____
      Address (Home): _____
      _____
      Phone (Home): _____(Work)_____
      Relationship to You: _____

   b. First Alternate: (Optional)
      Full Name: _____
      Address (Home):_____ _____
      _____
      Phone (Home): _____(Work)_____
      Relationship to You: _____

   c. Second Alternate: (Optional)
      Full Name: _____
      Address (Home): _____
      _____
      Phone (Home): _____(Work)_____
      Relationship to You: _____

3. In the event of your incapacity, do you desire that your Agent have full authority to make medical care decisions for you, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep you alive?

   YES_____ NO_____

   Specify any limitations: _____
_____

4. Do you desire that your Agent be given the right to authorize the removal of all artificial support systems if your Agent is convinced that your life is being artificially prolonged (1) if you have an incurable and irreversible condition that will result in death within a relatively short time, (2) if you become unconscious and, to a reasonable degree of medical certainty, you will not regain consciousness, or (3) if the likely risks and burdens of treatment would outweigh the expected benefits?

YES_____ NO_____

Specify any limitations: _____
_____

5. Do you desire that your Agent be given the right to authorize treatment for alleviation of your pain or discomfort, even if it may hasten your death?

YES_____ NO_____

Specify any limitations: _____
_____

6. Do you desire that your Agent have the discretion to authorize an autopsy, make anatomical gifts, and direct the disposition of your remains in the event of death?

YES_____ NO_____

Specify any limitations: _____
_____

7. Do you desire that your Agent also serve as your court appointed conservator should you need a conservator due to incapacity?

YES_____ NO_____

If no, name of other choice (optional):_____

8. Designate your primary physician, if you wish:

Full Name: _____
Address: _____
_____
Phone: _____

Dated: _____ By _____